STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. BUILDING _____ B. WING _____	09/17/2010

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OASIS HEALTHCARE AND REHABILITATION CENTER	660 DESERT LANE LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare re-certification and complaint survey conducted at your facility on September 14, 2010 through September 17, 2010, in accordance with 42 Chapter IV Part 483 Requirements for Long Term Care Facilities. The census at the time of the survey was 133. The sample size was 24 including 3 closed records. There was one un-sampled resident. There were 3 complaints investigated during the survey: CPT # NV00026274: This complaint contained one allegation. The allegation concerned incontinence care and could not be substantiated. CPT# NV00026342: This complaint contained three allegations. The first allegation addressed inadequate ceiling vent maintenance. The second allegation asserted that a resident was denied visitation. The third allegation stated that the facility was without a Social Worker. None of the allegations could be substantiated. CPT# NV00026007: This complaint alleged that the facility did not provide medications as ordered. This allegation was substantiated (see F Tag 309). The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 identified:	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to fully implement its policy to report allegations of abuse, neglect or misappropriation of resident's property to the appropriate state agencies. The facility failed to ensure all employees understood the facility's procedures in regards to abuse. Findings include: The agency's policy titled, "Abuse Prohibition" with a revised date of 2/2008, read, "...Component V: Reporting/Response 1. All alleged violations concerning abuse, neglect, or misappropriation of property are reported verbally immediately to the Administrator/Designee and other enforcement agencies, according to state law including the State Survey and Certification Agency (nurse aide registry or licensing authorities)." Nevada Regulatory Statute (NRS) 200.5093 indicated every person employed by a facility that provided care for an older person was a mandated reporter. If the employee knew or had reasonable cause to believe an older person had been abused, neglected, exploited or isolated, the	F 226		10/15/10

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F 226	Continued From page 2 employee must report to the appropriate agency no later than 24 hours after the employee became aware that abuse, neglect, exploitation or isolation did or may have occurred. The regulation named the local office of the Aging and Disability Services Division (ADSD) to receive elder abuse reports. A review of the facility's investigation of an allegation of staff to resident abuse indicated the facility did not report the allegations to ADSD as mandated by state law. On 9/15/10 at 2:30 PM, Employee #1 stated, "I thought I only reported to DAS (ADSD) if the allegation was substantiated. I have not routinely reported to ADSD." On 9/14/10, facility employees were asked to describe what they would do if they saw a co-worker hit a resident. The employees did not verbalize they would protect the resident or separate the employee and the resident. On 9/14/10 at 11:40 AM, Employee # 6 verbalized she would talk to the co-worker and report the event to the charge nurse. On 9/14/10 at 2:40 PM, Employee #8 verbalized, he would go and tell a supervisor or a nurse. On 9/14/10 at 2:50 PM, Employee #7 verbalized employee would talk to the co-worker and find out what's going on, then take the resident away and go to a charge nurse. On 9/15/10 at 11:30 AM, Employee #2 verbalized if the employee saw a co-worker hit a resident, Employee #2 would expect the employee to	F 226		

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F 226	Continued From page 3 immediately remove the resident from the situation, go to a supervisor and let the facility's abuse coordinator know what had occurred. During the abuse prohibition interviews on 9/14/10, facility employees were unable to correctly verbalize the name or title of the facility's abuse coordinator. On 9/14/10 at 2:40 PM, Employee #8 verbalized, "I'm not really sure." On 9/14/10 at 2:50 PM, Employee # 7 verbalized Employee # 2 was the facility's abuse coordinator. On 9/15/10 at 11:30 AM, per the facility administration, Employee #1 was designated as the facility's abuse coordinator.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		10/15/10

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F 279	Continued From page 4 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed for one resident receiving hemodialysis (Resident #16). Findings include: Resident #16 Resident #16 was a 71 year old female admitted to the facility on 9/1/10, with diagnoses including end stage renal disease, dialysis, congestive heart failure and hypertension. Review of the medical record on 9/16/10, revealed there was no care plan initiated identifying the problem, goals and approaches regarding the care, treatment and communication with the dialysis center. The only problem addressed on the resident's care plan related to the end stage renal disease diagnosis addressed Resident #16's nutritional status with the need for a renal diet. On 9/16/10 in the afternoon, the charge nurse confirmed there was no care plan initiated to address Resident #16's care and treatment of the dialysis catheter, transportation, and communication with the outpatient dialysis center. Cross refer F309	F 279		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		10/15/10

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F 309 SS=D	Continued From page 5 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents' needs were met to maintain the highest practicable well being for 2 of 24 residents (Residents #16, #17). Findings include: Resident #16 Resident #16 was a 71 year old female admitted to the facility on 9/1/10, with diagnoses including end stage renal disease, dialysis, congestive heart failure and hypertension. The physician's orders dated 9/1/10, revealed Resident #16 received outpatient dialysis three times a week, on Tuesday, Thursday, and Saturday. 1) On 9/16/10, Resident #16's medical record did not include the communication report from the dialysis center for Tuesday, 9/14/10. On 9/16/10 in the afternoon, the charge nurse confirmed the communication form was not on	F 309		

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F 309	Continued From page 6	F 309		

the chart. The charge nurse verbalized that usually the nurse who cares for the resident obtained the form from the resident when the resident returned from dialysis. The charge nurse added that sometimes the transporters did not notify the staff when a resident returned from dialysis.

Review of the Dialysis Communication Record form dated 9/14/10 documented the following under comments: "Please collect 24 hour urine. Start Wednesday until Thursday. Pls. (Please) put urine jug in refrigerator or cooler with ice every time patient collects urine. Pls. bring jug back on Thursday with patient to dialysis unit."

Since this communication record had not been reviewed upon Resident #16's return from dialysis on 9/14/10, the 24 hour urine specimen was not obtained as requested.

2) The physician's orders dated 9/1/10 included: "Monitor the shunt site every shift... Check Vital Signs upon return from dialysis."

Resident #16's Medication Administration Record (MAR) included the orders for monitoring the resident's shunt site and vital signs. There was no documentation Resident #16's vital signs were checked on 9/4/10 or 9/11/10, when the resident returned from dialysis.

Resident #16's MAR revealed there was no documented evidence the shunt site was checked on the following dates and corresponding shifts:
- 9/02/10 - 3-11, 11-7,
- 9/03/10 - 3-11, 11-7,
- 9/04/10 - 7-3, 3-11, 11-7,
- 9/05/10 - 7-3, 3-11, 11-7,

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F 309	Continued From page 7 - 9/06/10 - 7-3, 3-11, - 9/08/10 - 7-3, 3-11, - 9/09/10 - 3-11, - 9/10/10 - 3-11, - 9/11/10 - 7-3, 3-11, 11-7, - 9/12/10 - 3-11, 11-7 Cross refer F279 Resident #17 Resident #17 was readmitted to the facility on 07/23/10 with diagnoses including chest pain, opioid dependence, gastritis, pain, paralysis agitans, hypertension, tachycardia, and fracture. Resident #17's admission orders dated 07/23/10, included the medication Oxycodone 5/325 milligrams, one tablet, to be given by mouth every six hours for moderate pain. Review of Resident #17's Medication Administration Record (MAR) revealed the order was transcribed incorrectly as "PRN" (to be given as needed). On 09/16/10 at 3:00 PM, Employee #1 was interviewed. She reviewed the documentation and verified the admission order was incorrectly transcribed.	F 309		
F 322 SS=D	CPT #NV00026007 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities,	F 322		10/15/10

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F 322	Continued From page 8 and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper techniques for gastrostomy tube (G-tube) medication administration were followed to prevent aspiration for 1 of 24 residents (Resident #10). Findings include: Resident #10 Resident #10 was a 59 year old male admitted to the facility on 5/21/10, with diagnoses including intracranial hemorrhage, hemiplegia, dysphagia, and gastrostomy tube. On 9/16/10 at 11:30 am, Employee #9 was observed administering medications to Resident #10 through his G-tube. Employee #9 crushed all of the medications individually and mixed each with water. Prior to administering the medications, Employee #9 checked for placement of the G-tube through auscultation. Employee #9 connected a large syringe to the G-tube, instilled about 30 cc (cubic centimeters) of air though the tube, and listened to Resident #10's abdomen. Employee #9 did not check Resident #10's G-tube for residual fluid through aspiration of the tube. Employee #9 then instilled water through the syringe, followed by the diluted medication. She	F 322		

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F 322	Continued From page 9 administered each medication, alternating with water, until the medications were completed. Following the procedure, Employee #9 indicated she checked Resident #10's G-tube for residual by aspiration once a shift. Employee #9 revealed a residual check was done earlier in the day and did not recheck prior to the current medication administration. Review of the facility policy titled "Enteral Feeding - Documentation" dated 7/2009, revealed: - "...3. A. Check for placement before the initiation of formula, water and medication delivery, or at least every eight (8) hours..." Review of the facility policy titled "Enteral Feeding - Administering Medications Through Feeding Tubes" dated 7/2009, revealed: - "...6. Verify placement by air auscultation and aspiration of stomach contents ..."	F 322		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		10/15/10

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F 425	Continued From page 10 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and document review, the facility failed to have a process in place to ensure timely ordering and receiving of medications from the pharmacy for 1 of 24 sampled residents (Resident #23), and 1 unsampled resident (Resident #25). Findings include: Resident #23 Resident #23 was admitted on 9/1/09, with diagnoses of osteoporosis, dysphagia, and depression. According to the recapitulated physician orders dated 9/1/10, the resident's medications included, Foltx (a combination of Folic acid and B vitamins) one tablet every day and Clarinex 5 milligrams (an antihistamine) one tablet daily. During observation of a medication pass on 9/15/10 in the morning, Employee #3 prepared medications for Resident #23. Employee #3 indicated he did not have the Foltx or Clarinex in the medication cart. The employee indicated he "believed" the Clarinex was "house stock" kept in the facility, but was not sure about the Foltx. After Employee #3 administered other physician	F 425		

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F 425	Continued From page 11 ordered medications to Resident #23, Employee #3 went to the medication room for the "house stock" Clarinex. Employee #3 stated, "We don't have Clarinex, only Claritin. (Employee #4) will re-order the Clarinex and Foltx from the pharmacy." On 9/15/10 at 9:10 AM, Employee #4 stated, "I called the pharmacy to reorder the Foltx, but the pharmacy said it wasn't on the profile. I re-sent the order and re-ordered the Clarinex." On 9/15/10 at 10:20 AM, the pharmacy delivered the Foltx and the Clarinex and Employee #3 administered both medications. On 9/16/10 at 1:45 PM, Employee #2 provided information from the pharmacy which indicated the Foltx medication had not been filled by the pharmacy when the physician initially ordered the medication on 8/7/10. According to Employee #2, Foltx should have been in the "house stock" medications. Resident #25 During observation of a medication pass on 9/16/10 in the morning, Employee #9 prepared medications for Resident #25. Employee #9 indicated she did not have the Folic acid 1 milligram in the medication cart and would have to re-order the Folic acid from the pharmacy. Employee #9 stated, "Refills for medications should be ordered from the pharmacy when the nurse sees that there is only 2-3 days left in the current pack, so you don't run out." On 9/16/10 at 10:20 AM, the pharmacy delivered the Folic acid and Employee #9 administered the	F 425		

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F 425	Continued From page 12 medication. On 9/16/10 at 1:45 PM, Employee #2 indicated refills for medications should be ordered from the pharmacy when the nurse notices there are only 2-3 days left in the current pack. The facility's policy titled, "Ordering and Receiving Medications from Pharmacy" with an original date of 4/03, read, "...2. Information concerning repeat medications (refills) is written on a medication order form provided by the pharmacy for that purpose, or transferred to the form on a peel-off label, and ordered as follows: A. Reorder medications in advance of need to assure an adequate supply is on hand..."	F 425		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure laboratory services were provided as ordered by the physician for 2 of 24 sampled residents (Resident: #11, #18). Findings include: Resident #18 Resident #18 was admitted to the facility with diagnoses that included pulmonary embolism, hypertension, bacteriemia, obesity, and asthma.	F 502		10/15/10

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F 502	Continued From page 13 A review of Resident #18's clinical record was conducted on 09/15/10. The record contained a physician's order dated 07/12/10, for two laboratory tests; a complete blood count (CBC) and a renal panel. The laboratory results could not be located in the clinical record. On 09/15/10 at 11:38 AM, Employee #5 stated that she had looked through Resident #18's clinical record but could not find the laboratory results. Employee #5 also indicated she called the laboratory and that the laboratory had no record of the test being ordered and did not have the test result. Resident #11 Resident #11 was a 49 year old male originally admitted to the facility on 10/16/09, and readmitted on 8/18/10, with diagnoses including epileptic seizure disorder, encephalopathy, urosepsis, and percutaneous endoscopic gastrostomy tube. Review of the medical record on 9/16/10, revealed Resident #11 was receiving Keppra 500 mg (milligrams) twice a day (BID) since 1/2010, for management of his seizure disorder. A Keppra level was drawn on 6/14/10, which indicated the Keppra level was 1.8 mcg/mL (micrograms per milliliter). The laboratory report on Resident #11's medical record included the notation " *** Unable to flag abnormal result(s), please refer to reference range(s)..." The laboratory report indicated the therapeutic range for Keppra levels were: - Drug Dosage Trough Peak	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295017	A. BUILDING _____ B. WING _____	09/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS HEALTHCARE AND REHABILITATION CENTER	660 DESERT LANE LAS VEGAS, NV 89106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 14 - 500 mg BID 3.1-10.0 mcg/mL 10.0-25.0 mcg/mL -1000 mg BID 4.9-37.1 mcg/mL 30.0-40.0 mcg/mL -1500 mg BID 7.0-34.0 mcg/mL 36.1-70.0 mcg/mL -Toxic level: Not established Resident #11's laboratory report did not identify the Keppra level drawn was a Trough or Peak level. The laboratory results dated 6/14/10, were signed off by the attending physician with no change in Resident #11's medication orders. A repeat Keppra Level was drawn on 7/15/10. The results indicated the Keppra level was 2.3 mcg/ml. There was no documentation on Resident #11's laboratory report that indicated the Keppra level was a Trough or Peak level. The physician's order dated 7/19/10, increased Resident #11's Keppra to 750 mg BID. The physician's order dated 8/5/10, included an order to repeat the Keppra level on 8/6/10. The nurse's notes dated 8/7/10, revealed Resident #11 was noted to have continuous seizure activity for 45 minutes. The resident was transferred to the acute care facility on 8/7/10. There was no documented evidence the repeat Keppra level was drawn on 8/6/10, as ordered. On 9/15/10, the charge nurse confirmed there were no Keppra level results from 8/6/10.	F 502		